**MEMORANDUM**

TO: Medicaid Eligibility

FROM: _____ County Department of Social Services

RE: Emergency Services for an Alien

Date: _____

Applicant's Name: _____ Aid Program/Category: _____

MID_____ Sex:_____ DOB: _____

Application Due Date (45th/60th/90th Day): _____

The individual named above has applied for Medicaid payment for emergency care as defined in MA-2505/MA-3405 of the Medicaid Eligibility Manuals. The following dates of service are requested, and I certify that I **am enclosing appropriate medical records to cover each date requested:**

_____ _____

_____ _____

_____ _____

**NOTE**: **Determination of eligibility cannot be made without the required medical records for the dates of service requested. Do not send medical records for dates other than those indicated.**

County Contact Person:_____

Telephone No. _____ Fax No.: _____

**(When a decision is made, a copy of this sheet will be faxed to the agency before the record is returned by mail.)**

**********

Emergency services approved (TO BE COMPLETED BY MEDICAL POLICY STAFF (DMA):

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Comments:_____

_____

_____

_____

_____

_____

Signature of Reviewer Date